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# HEALTH POLICY ADMINISTRATION AND BI-NATIONAL ELDERLY MIGRANTS IN THE USA/MEXICO BORDER. THE CASE OF THE CIUDAD JUAREZ/EL PASO REGION[1,2]

## La administración de políticas de salud y la migración binacional de personas adultas mayores en la frontera Estados Unidos/México. El Caso de la Región de Ciudad Juárez/El Paso.

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*ABSTRACT*

*This article discusses the absence of health policies addressed to attend elderly Mexican migrants that have migrated and have been living in the US for at least 10 years and dwelling on the Juarez/El Paso border region. Grounded Theory was used and a sample population of 24 participants of 60 years old and more was consulted. Results shows that a third of the sample crosses the border into Mexico searching for medical services and needs to travel an average of 21 miles to achieve it. The research concludes that there is a little knowledge about the pattern of Mexican elderly migrants into the USA and a little recognition of this group as a recipient of medical services in the USA. In addition, it seems that local governments and local health institutions on both sides of the border need to implement innovative schemes of administration and policy design to address those needs of such migration flow from Mexico.*

***Keywords:*** *Migration; Elderly population; Health policy; Border.*

***RESUMEN***

*Este trabajo analiza la ausencia de políticas de salud hacia la población de personas adultas mayores que tienen al menos 10 años de haber emigrado de México hacia los Estados Unidos en la región fronteriza de Ciudad Juárez y El Paso. La investigación utilizó la Teoría Fundamentada, basada en una muestra de 24 participantes mayores de 60 años. Los resultados indican que una tercera parte de los participantes cruzan la frontera hacia México en busca de atención médica y necesitan viajar un promedio de 34 kilómetros. Se concluye que existe una ausencia de reconocimiento acerca de la migración de adultos mayores como un nuevo grupo demandante de atención y servicios médicos en Estados Unidos y que las instituciones de salud y los gobiernos locales fronterizos necesitan implementar esquemas innovadores de administración y diseño de políticas para atender coordinadamente los servicios médicos para este nuevo tipo de flujo migratorio desde México.*

***Palabras clave:*** *Migración; Personas adultas mayores; Políticas de salud; Frontera.*

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# Introduction

A review of the literature about elder people and border regions presents an array of multidisciplinary scholarly topics (Delgado et al., 2022; Montero-López et al., 2019; Salazar-Barajas et al., 2020; Zhigaltsova, 2021). However, there is a paucity of scholarly literature and research among Mexican and American scholars related to migration of elderly people from Mexico into the U.S. (Judkins, 2007; Zunker & Cummins, 2004; Llera & López-Nórez, 2012; López-Nórez, 2017; Vargas-Bustamante, 2020). In this paper, we present our findings about the impact on the elderly of the process of migration from Ciudad Juarez to El Paso, with specific attention of their access and use of health systems and related institutions. We believe that our research may be the first efforts to understand the needs and challenges faced by individuals who migrate from Mexico to the U.S in their elderly years (defined as 60+ years of age).

Anderson (2003) and Zunker & Cummins (2004) discuss the fast rate of growth of the elderly population in El Paso. Several authors report on the poor quality of life and health conditions of the elderly in this border region (Zunker et al., 2005; Mier et al., 2008). López-Nórez (2017) found that migration of elderly Mexicans into the U.S. presents unique challenges. One belief is that family reunification is the most important reason for the migration of retired Mexican elderly populations into El Paso (López-Nórez, 2017). There is a concern that migration of Mexican elderly population may increase the financial pressure in the U.S. health system as it has happened in other contexts, such as Europe (Getz-Sheftel et al., 2023; Neergaards, 2021). A few studies explore the timing of migration on health outcomes, but most of them focus on mortality, and not in the quality-of-life the elder migrants experience as they are ageing in the U.S.

The existent academic literature barely shows that the migration of elderly people from Mexico into the U.S. is becoming a more common process along the Juarez /El Paso border region (López-Nórez, 2017). According to the U.S. Census Bureau (2013) in El Paso County in 2010, there were 82,223 (10.2%) persons 65 and older; 70,000 (10.7%) residing in El Paso city limits; and approximately 10,952 of the housing occupied by the elderly was located outside of the city limits in impoverished, unincorporated communities within the county. By 2020 there were 108,308 (13.1%) persons 65 and older (US Census Bureau, 2024).

López-Nórez (2017) conducted several in-depth interviews with a purposive sample of elderly individuals who migrated to El Paso when they reached 30 or more years of age. Findings show that one of their major pressures was the absence of knowledge and skills that have created barriers to accessing needed resources, including health care, economic support, and assistance with housing and other social services. For instance, most of the research participants attributed these challenges to: 1) a lack of knowledge about the most important agencies that provide support for the elderly people, 2) a little familiarity on how to contact institutions and organizations, 3) communication barriers based on language differences, and 4) a lack of confidence to speak with public officials. This lack of knowledge and skills inhibited their ability to obtain the necessary services and resources to improve their quality of life while living in the U.S.

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# 1. Method

We adopted an exploratory research design, using a Grounded Theory approach. We developed a semi-structured interview schedule for specific use in this study to conduct in-depth interviews (1.5 hours) with participants to capture deep meaning and nuances from the respondent's lived experiences. The research questions guiding this study included: 1) what motivated the individual to migrate and their experiences with migration; 2) their present living situation including home and community; 3) their perceptions of their health status; 4) where they access health services and why, and 5) the supports and challenges of accessing health care services. We obtained approval for the study from the institutions Institutional Review Board prior the initiation of the project.

We used a quota sample to recruit subjects, selecting: 24 Mexican men and women who migrated in their later life (defined as 60 years of age or older) and lived in the U.S. for at least 5 years continuously since migrating. The 24 participants were stratified by gender (12 men and 12 women) and by age (60 to 70 and 71+ years of age). The stratification was based on the health care utilization patterns and cost of health care (Neuman et al., 2015).

Recruitment of participants occurred in several ways. Local agencies in El Paso County agreed to distribute information sheets about the research project and encouraged them to contact the individuals listed at the end of the announcement. We put up signs in local food markets, retail settings and churches in Hispanic neighborhoods. We also gave presentations of the project at local health and social service programs serving the elderly. Finally, snowball sampling became a major source for recruitment; participants who completed the interview shared the announcement with others in their network and encouraged their participation.

Interested participants established contact with the research team by telephone or email; screen-ing for eligibility occurred at this contact. If eligible, a consent form was discussed and read in the participant's primary language; and if they agreed to participate, we scheduled a time for the interview. To ensure anonymity, no identifying information (e.g., name, address or phone number) was put in record from the initial contact; it was destroyed once the participant's interview was completed. At the interview, the interviewer reviewed the consent form again and obtained the participant's signature.

We developed a structured interview guide to use in this project. It addressed into one's perception of the experience of migration in their later life; the type, location and challenges of accessing health and social services either in the El Paso, Texas or in Juarez, Mexico; and differences in experiences for wom-en and men. The interview guide also included demographic data (e.g., age, gender, age at migration, marital status, and members living in the household, retirement/work status, and health history). The interviewer took field notes to capture observational data, describing things seen, heard, or experienced during the interviews. The field notes document the researcher's reactions, ideas, questions, and emerg-ing insights and findings (Mount et al., 2007).

Initially, we used thematic content analyses, cataloging thematic categories and subcategories that emerged from open coding of the interview data. We paid close attention in comparing themes across within the interview data and began to identify patterns. The next phase delved into more detailed analysis of the data using ATLAS-ti software to assist in the analysis. As themes, categories, concepts, or principles of organization emerged, the research team considered the plausibility of new understandings and

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explored them through the data. We searched through the data to identify discrepancies or interruptions in the patterns and incorporating these inconsistencies into larger constructs (Marshall & Rossman, 1999).

## 2. Findings

The migration of an elderly population has received little attention in the national or global academic literature. Authors have primarily followed migration patterns of elder people returning from foreign contexts or external national regions to their country of origin (Handlos et al., 2015; Nedelcu et al., 2024; Wang et al., 2017). According to our knowledge, in the U.S./Mexico border region there exists a different migration pattern for the elderly population. Rather than returning to their home country to stay for their last years of their lives, as it happened with the Pakistanies in Sweden or with the Bosnians in Denmark (Næss & Vabø, 2014; Handlos et al., 2015). In our research study we found that in the Ciudad Juarez/El Paso border region, there exist Mexican elderly people that immigrate into the U.S. to spend the last part of their lives together with their children and grandchildren.

Most of the research about elder population who migrated into the U.S. addresses individuals who migrated earlier in their lives and aged while in the U.S. (Altangerel & Van Ours, 2017; Becerra & Kiehne, 2016; Hanson & Mc Intosh, 2009). Therefore, we designed this study as a pilot project that may be among the first to target the migration of elderly individuals from Mexico into the U.S.

The United States and Mexico border region is an area that has historically encompassed diverse social, cultural, political and economic interactions among the local inhabitants. One of the most common to this region has been the composition of families where the younger generation possesses double citizenship, and the adult members maintain only one. When these younger members, with U.S. citizenship, grow, they often move to live in the United States. As their parents age, their families in the U.S. encourage them to move to the U.S. to be with the family. These elderly parents may hold a different immigration status that avoids the quote standards if they are migrating to live with family who are living in the U.S. and are U.S. citizens. Moreover, this type of immigration is not subject to those typical quotas applied to immigration. According to the Immigration and National Act (INA) of 1965 the parents of U.S. citizens are considered "immediate relatives", and this migration category enjoys of unlimited annual visas (Cepla, 2018; Zong et al., 2019). In 2016, 48% of the over one million new green card holders were immediate relatives of U.S. citizens (Cepla, 2018). The percentage of parents that benefit from acquiring legal immigration status through their sons or daughters may vary among the different sub-regions or sectors along the United States/Mexico border region. To illustrate, according to U.S. official immigration data of 2017, foreign-born persons with legal status that were 65 years and older accounts for 11.8% of the total foreign-born population with legal status in Texas, 15.6% in New Mexico, and 15.6% in Arizona (Migration Policy Institute, 2017).

In the Ciudad Juarez/El Paso border region, we found that the migration of elderly people from Mexico into the U.S. is becoming more common. Data from our study revealed that elderly migrants mov-ing from Ciudad Juarez into El Paso was clustered in two main groups according to the country of origin of their retirement pension or source of income. One group of subjects used to live in Ciudad Juarez, but worked most of the time in the U.S. Their retirement pension and social benefits came from American

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institutions. A second group lived and worked in Mexico: therefore, their retirement pension and social benefits came from Mexican institutions. The origin of the source of income and the side of the border where they received social benefits created relevant differences in their conditions of life. In Tables 1 to 3, we present some of the demographic information, focusing on social, economic, educational, and cultural differences among elderly migrants who have moved to live into the U.S. after they reach 60 years old.

**Table 1.** Education and Language Skills

| Variable | All N = 24 | % with American Retirement Livelihood N=16 | % with Mexican Retirement Liveli-hood N=8 | % Retirement Livelihood Total N = 24 |
|---|---|---|---|---|
| Gender | | | | |
| Male | 12 | 25.00 | 25.00 | 50.00 |
| Female | 12 | 41.66 | 8.34 | 50.00 |
| Education | | | | |
| Primary School and below | 10 | 33.34 | 8.34 | 41.66 |
| | | | | |
| High School completion | 7 | 16.66 | 12.51 | 29.16 |
| | | | | |
| College and above | 7 | 16.66 | 12.50 | 29.16 |
| Language Skills | | | | |
| Monolingual Person (Spanish) | 13 | 33.34 | 20.84 | 54.16 |
| | | | | |
| Bilingual Person (English / Spanish) | 8 | 29.16 | 4.16 | 33.34 |
| | | | | |
| Partially Bilingual (English / Spanish) | 3 | 4.16 | 8.34 | 12.57 |

Source: Own elaboration.

The total number of subjects participating in this study was 24. The sample shows an even distribution by gender. The group relying in American retirement benefits was larger (66.66 %) than the group relying in Mexican retirement benefits (33.34%); women were more likely to rely of American benefits than men. Overall, the level of education of participants relying on U.S. retirement was more likely than Mexican retirees to only complete primary school of less.

However, those on U.S. retirement were only slightly more likely to complete secondary and post-secondary education than those of the Mexican retirement system. Their knowledge of the English language demonstrates that Spanish is the primary language across both retirement systems (54.16%). In that sense,

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those on the U.S. system are almost three-times more likely to speak or partially speak English than those in the Mexican system. This is not surprising, given that working in the U.S. would increase the necessity to acquire at least some English proficiency.

Table 2 presents the source of income and housing tenure of the sample population. Based on results, it seems that there is a high percentage of participants (37.50 %) who do not have a retirement pension or financial support rather they are still working or may receive family support for their subsistence. These participants are the ones who might face major challenges to deal with health problems since some of them do not have access to health coverage.

On the contrary, it is relevant that there are a small number of participants (8.34 %) that enjoy of simultaneous retirement pensions and social benefits from both Mexico and the U.S. This group of subjects are the ones that enjoy the best health coverage in the region. They can select where to receive medical treatment and prescriptions. In addition, this group may also have strong economic conditions among the research subjects; but further analysis would be required to establish this relationship. As one participant stated:

> "*I worked for about 30 years in Mexico as a boot maker and as school janitor; after I retired there, I moved to El Paso, and I have been working in the United States since I obtained my residency 6 years ago… I am retired and I have medical services from the IMSS, in Mexico. They give me my monthly check up and they give me medication there too….here, in the United States I have medical insurance too…*"

Regarding housing, most participants (79.16%) lived in a private home and there was only a small percentage (20.84%) living in public housing. Research subjects living in public housing were those who mostly developed their working trajectories within the U.S. This pattern was present among the five research subjects that were interviewed within public housing projects. Housing location suggest that people that work most of the time in the U.S., while living in Juarez during their working life did not care about the location and administration of the health services. When they retired, it required them to obtain housing in the U.S. to access human and health services.

**Table 2.** Main Source of Income and Housing Tenure

| Variable | All N = 24 | %American Retirement Livelihood N=16 | %Mexican Retirement Livelihood N=8 | %Total Retirement Livelihood N = 24 |
|---|---|---|---|---|
| Gender | | | | |
| Male | 12 | 25.00 | 25.00 | 50.00 |
| Female | 12 | 41.66 | 8.34 | 50.00 |
| Source of Income | | | | |
| Formally worked and retired in one Country | 13 | 25.00 | 29.16 | 54.16 |

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| Variable | All N = 24 | %American Retirement Livelihood N=16 | %Mexican Retirement Livelihood N=8 | %Total Retirement Livelihood N = 24 |
|---|---|---|---|---|
| | | | | |
| Formally worked and retired on both Countries | 2 | 0 | 8.34 | 8.34 |
| | | | | |
| Husband / Spouse Pension | 6 | 16.66 | 8.34 | 25.00 |
| | | | | |
| None of the above (still working, family support, other) | 3 | 8.34 | 4.16 | 12.50 |
| Housing Tenure | | | | |
| Living in Public Housing | 5 | 20.84 | 0 | 20.84 |
| | | | | |
| Living in Private Housing | 19 | 45.83 | 33.33 | 79.16 |

Source: Own elaboration.

Table 3 provides participant´s information about their period or date of migration from Mexico into El Paso, Texas. According to our data, only 25% of the sample population had five years living in El Paso. We noticed that 16.66% of those subjects worked and lived their entire productive live in the Mexican side and when we observed the patterns of home companion, we found out that none of such participants lived alone in the U.S. These Subjects that used to live most of their life in Mexico either live with spouse/husband (20.84%) or with family members (12.50%). These findings confirm what Angel et al. (2010) and Wasem (2004) have stated that elderly migrants tend to migrate to the U.S. to live with family members in contrast to those who migrate searching for working opportunities.

**Table 3.** Migration Period and Home Companion

| Variable | All N = 24 | American Retirement Livelihood N=16 | Mexican Retirement Livelihood N=8 | %Total Retirement Livelihood N = 24 (%) |
|---|---|---|---|---|
| Gender | | | | |
| Male | 12 | 25.00 | 25.00 | 50.00 |
| Female | 12 | 41.66 | 8.34 | 50.00 |
| Migration to El Paso | | | | |
| More than10 years ago | 8 | 29.16 | 4.16 | 33.33 |

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| Variable | All N = 24 | American Retirement Livelihood N=16 | Mexican Retirement Liveli-hood N=8 | %Total Retirement Livelihood N = 24 (%) |
|---|---|---|---|---|
| | | | | |
| 6 to 10 years ago | 10 | 29.16 | 12.50 | 41.67 |
| | | | | |
| 5 years ago | 6 | 8.34 | 16.66 | 25.00 |
| Living with | | | | |
| Living with their family members | 4 | 4.16 | 12.50 | 16.66 |
| | | | | |
| Living Alone | 9 | 37.50 | 0 | 37.50 |
| | | | | |
| Living with Spouse/Husband | 11 | 25.00 | 20.84 | 45.84 |

Source: Own elaboration.

According to the obtained data, the sample of participants lived in the U.S. for many years post-migrating; 58.32% lived in the U.S. six or more years, with almost 30% residing for more than ten years. One explanation may be associated with their years of employment in the U.S. When they retired, they may have established a network of friends, and/or obtained residency to access their U.S. retirement benefits. As one of the participants commented:

> *"…my husband worked his entire life in the U.S.A and we made many friends in El Paso… we used to come to parties and make many friends in El Paso… I got used to the life in the U.S.… when my husband passed away it was not difficult for me to move to live in El Paso".*

This might also explain why those living in the U.S. after migrating were also more likely to be living or with their spouses (62.5%). For those living in Mexico, whether working in the U.S., their recent migration could create challenges to adjusting to U.S. life. One participant describe it as follows:

> *"…I live right next to my daughter… it is because her property is so big, and she gave us a piece of it... we have a trailer home... I barely have friends in here... I do not like to go out very often… it is because my husband does not like to go out... Why do I need to have friends if I barely go out ".*

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## 3. Medical Service Provision and Elderly Migrants

We have discussed that most of the sample population in this study has worked and retired either in the U.S. (33.34 %) or in Mexico (20.84 %) and only a small percentage of them worked and retired from both Mexico and the U.S. (8.34 %). In addition, 12.50% of the participants were still working and subsisting through their salaries.

This information was relevant to understand the characteristics, or the type of health coverage enjoyed by the sample population on both sides of the U.S./Mexico border. Our findings, presented in Table 4, show that 58.32% of our research subjects had health insurance in the U.S. These results also suggest that the larger the period of migration the most common was to search for health insurance in the U.S. As was expressed by Subject 2:

> "*…my daughter told me to go to that Clinic because sometimes I used to bring some medication from Juarez and she told me to go to a Clinic here so they could do a checkup and they could give me medication, and she is the one that took me to the Clinic... When I receive medical attention, everybody speaks Spanish there...*"

Our data also display that 16.65% of the sample population had access to Health Insurance on both sides of the border. This situation allowed them to have more alternatives to choose where they preferred to receive medical services, medical treatments or provision of medicines. This situation was illustrated by Subject 1 who stated:

> "*….here, in the United States I have medical insurance too… Blue Cross Blue Shield… I have seen a doctor here so I could have an open file and medical history here… if there is an emergency, I could use my medical services here… I go to Juarez on Saturdays when I am not working… to see my daughters and so then I just take advantage and go to the doctor*".

**Table 4.** Health Insurance Coverage

| Variable | All N = 24 | % Migrating El Paso >10 years ago N=8 | % Migrating El Paso 6-10 years ago N=10 | % Migrating El Paso < 6 years ago N=6 |
|---|---|---|---|---|
| Gender | | | | |
| Male | 12 | 16.66 | 16.66 | 16.66 |
| Female | 12 | 16.66 | 25.00 | 8.34 |
| Health Insurance Coverage | | | | |
| Insured in U.S.A | 14 | 20.84 | 29.16 | 8.34 |
| | | | | |

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| Variable | All N = 24 | % Migrating El Paso >10 years ago N=8 | % Migrating El Paso 6-10 years ago N=10 | % Migrating El Paso < 6 years ago N=6 |
|---|---|---|---|---|
| Insured in Mexico | 4 | 4.16 | 4.16 | 8.34 |
| | | | | |
| Insured in both Mexico and the U.S.A | 4 | 4.16 | 4.16 | 8.34 |
| | | | | |
| Uninsured in both Mexico and the U.S.A | 2 | 4.16 | 4.16 | 0 |

Source: Own elaboration.

The opportunity of a certain number of subjects (16.65%) to choose in what side of the border they would like to receive medical services was also relevant for their self-confidence and quality of life since they felt secure to face any emergency while they visit or conduct activities on both sides of the border. A good sign identified by this study is that the percentage of elder migrants that lacked some type of health insurance in the U.S. or in Mexico was low (8.34%). Even when these subjects recognized that they formally lacked health insurance they were not totally unprotected on both Ciudad Juarez and El Paso.

On both sides of the border, they had alternatives to receive some type of medical services. In the U.S. this population might found access to health services or primary care attention and in Mexico such population enjoys of full medical coverage by law. These was confirmed by a round table session with U.S. and Mexico academic specialists and decision makers as the U.S. Decision maker #1 stated:

> "*…in our Medical Institution, when people become legal, we give them five years and then they lose their medical discounts… they lose benefits because they now have access to other options like Medicare or Medicaid after five years… sometimes this people depend on others to go for medical visits in Mexico and this people do not want to cross the border*".

And complemented by the Mexican Decision Maker #1 who stated:

> "*In Mexico, health services are free for elderly… when the problem or disease is complex, we send them to Mexico because here is very expensive… and in Mexico they can get services for free … medical services are by law offered for free*".

In Table 5 we present the universal medical Institutions that provided medical attention to participants of this study on both sides of the border. Results showed that 91.64% of the entire sample population was covered by health insurance either in an American health institution (66.66%) or in a Mexican health institution (24.98%). The factor that most participants expressed that they had health insurance or health coverage in the U.S. might be partially truthful. It is real that they had access to health provision

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within some local health institutions in El Paso, although, this factor did not guarantee that participants enjoy of a health insurance which provided them of full coverage to their health needs.

**Table 5.** Medical Service Provision

| Variable | All N = 24 | % Migrating El Paso >10 years ago N=8 | % Migrating El Paso 6-10 years ago N=10 | % Migrating El Paso < 6 years ago N=6 |
|---|---|---|---|---|
| Gender | | | | |
| Male | 12 | 16.66 | 16.66 | 16.66 |
| Female | 12 | 16.66 | 25.00 | 8.34 |
| Medical Service Provision | | | | |
| American Health Institutions (Insurance Coverage) | 16 | 25.00 | 29.16 | 12.50 |
| | | | | |
| American Health Institutions (No Insurance Coverage) | 2 | 4.16 | 4.16 | 0 |
| | | | | |
| Mexican Public Health Institutions | 5 | 4.16 | 8.34 | 8.34 |
| | | | | |
| Mexican Private Health Institutions | 1 | 0 | 0 | 4.16 |

Source: Own elaboration.

On the contrary, we found out that 8.34% of the sample population had access to medical institutions which provided basic medical services but not comprehensive coverage in case of the necessity of specialize medical attention or hospitalization. In other words, an important number of participants enjoyed of underserved medical attention in El Paso, Texas. Overall, at that time, the three largest providers of medical services to our sample population on both Ciudad Juarez and El Paso were the Mexican Institute for Social Security (IMSS) 16.66%, private doctors 12.50%, and the University Medical Hospital 8.34%.

A factor of considerable attention in this research was to learn about the health status of the sample population. Official Mexican data pointed out that one third of the people of 60 years and older required some type of care or health support (Guerrero, 2015). Diabetes mellitus and cardiovascular diseases were among the three major causes for death among the Mexican elder. This study found out that chronicle diseases were the most frequent health problems experienced by participants. Data in Table 6 demonstrates that 66.66% of the total sample population had health problems related to diabetes and / or hypertension.

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**Table 6.** Health Conditions of Elderly Migrants

| Variable | All N = 24 | Migrating El Paso >10 years ago N=8 | Migrating El Paso 6-10 years ago N=10 | Migrating El Paso < 6 years ago N=6 |
|---|---|---|---|---|
| Gender | | | | |
| Male | 12 | 16.66 | 16.66 | 16.66 |
| Female | 12 | 16.66 | 25.00 | 8.34 |
| Diseases | | | | |
| Diabetes & High Blood Pressure | 16 | 25.00 | 29.16 | 12.50 |
| Arms, Legs, Back and Hip Injuries | 2 | 8.34 | 0 | 0 |
| Heart & Circulatory System Diseases | 3 | 0 | 8.34 | 4.16 |
| Other Diseases | 1 | 0 | 4.16 | 0 |
| None | 2 | 0 | 0 | 8.34 |

Source: Own elaboration.

This health pattern observed within the sample population confirmed the predominant health problems experienced within the Mexican society. Independently from the period of migration, more than 60% of participants suffered of diabetes. The second most relevant health affectation among participants was related to heart and circulatory diseases (12.50%). The prevalence of such type of diseases among participants made more relevant to have access to full medical coverage.

Chronicle diseases and heart diseases demand permanent medication, medical reviews, and costly treatments which in the long term become serious financial burdens to deal with both for patients and for their families. Findings form our research display that the four major health problems experienced by our sample population during the last six months were hypertension, 21%; cataract surgery, 8.4%; knee surgery, 8.4%; and diabetes, 4.2%.

As we have already pointed out 66.66% of the total sample population had health problems related to diabetes and /or hypertension, and another 12.50% of these participants, presented health problems related to heart and circulatory diseases. Based on such health patterns in Table 7 we present results about the frequency of medical visits and distance to medical services from our sample population. Our data results suggest that almost 50% of the total sample population attended to medical visits at least once every three months. Such frequency on visiting medical institutions for periodical reviews, concedes importance to the proximity of the medical place where subjects receive medical attention.

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**Table 7.** Frequency of Medical Visits and Distance to Medical Services

| Variable | All N = 24 | % Migrating El Paso >10 years ago N=8 | % Migrating El Paso 6-10 years ago N=10 | % Migrating El Paso < 6 years ago N=6 |
|---|---|---|---|---|
| Gender Male | 12 | 16.66 | 16.66 | 16.66 |
| Female | 12 | 16.66 | 25.00 | 8.34 |
| Frequency of Medical Visits | | | | |
| Monthly | 4 | 0 | 12.50 | 4.16 |
| | | | | |
| Quarterly | 8 | 16.66 | 12.50 | 4.16 |
| | | | | |
| Bi-annual | 6 | 12.5 | 8.34 | 4.16 |
| | | | | |
| Annual | 3 | 0 | 8.34 | 4.16 |
| | | | | |
| Occasional | 3 | 4.16 | 0 | 8.34 |
| Average Distance | | | | |
| 5 miles or less than 6 | 12.50 | 20.84 | 4.16 | |
| | | | | |
| 6 to 10 miles | 4.16 | 4.16 | 0 | |
| | | | | |
| 11 to 20 miles | 4.16 | 4.16 | 8.34 | |
| | | | | |
| 21 miles or more | 12.50 | 12.50 | 12.50 | |

Source: Own elaboration.

Data results on Table 7 show that 37.50% of the total participants received medical care in medical institutions located within an average distance of 5 miles or less. In this decision, external reasons were more decisive than personal reasons. Our results show that more than 30% of the sample population with medical insurance in the U.S. was assigned to the medical place where they received medical services and only 12.50% of the subjects choose the place to receive medical care taking in consideration the aspect of proximity.

This short proximity contributes to guarantee fast medical attention in case of an emergency and to facilitate the movements and transportation of participants to attend medical periodical reviews. This might also explain why almost 90% of the participants drove their own cars to attend medical appoint-

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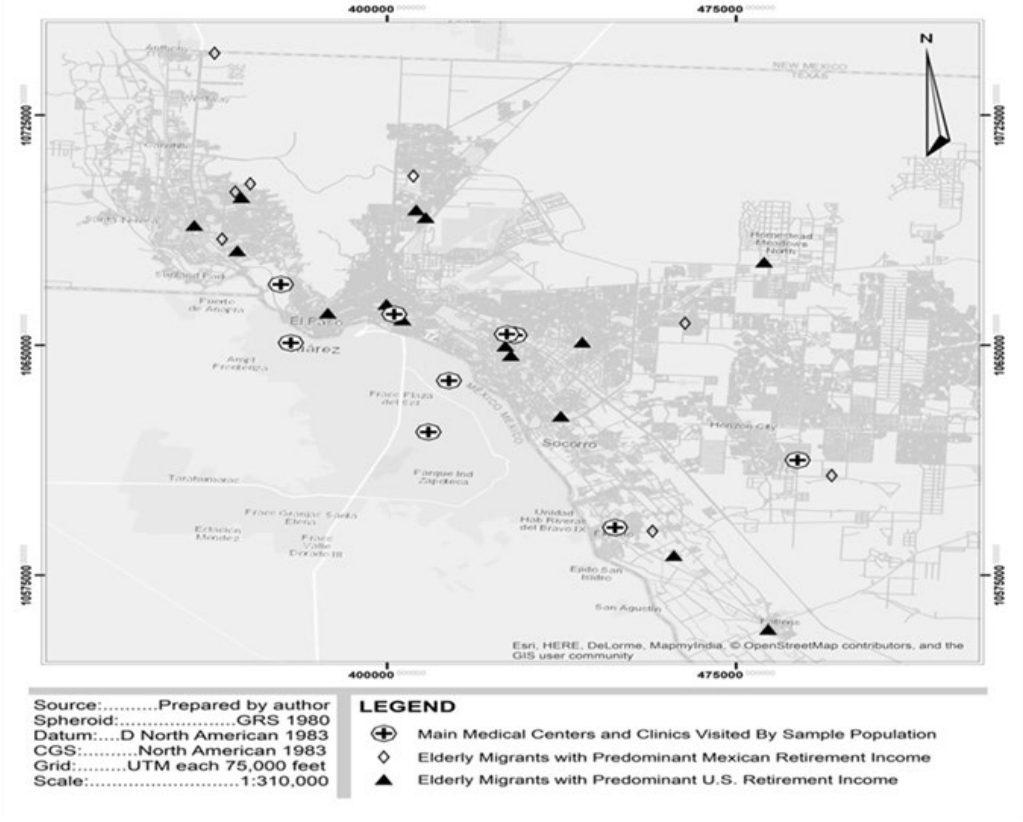
ments and even if they had taken the public transportation system, they had not needed to spend too much time to attend medical appointments.

There were also another considerable group of participants who needed to travel longer distances to receive medical attention. Data results on Table 7, show that 37.50% of the research participants needed to travel 21 miles or more to receive medical attention. This was the group that faced more disadvantages to access to medical service provision. The larger number of these research participants belonged to the group that used to live and worked in Mexico, and therefore, received their retirement pension and social benefits from Mexican institutions. Figure 1 shows how within our sample population those receiving social benefits and medical coverage in Mexico were settled in further geographic distances to the Mexican boundary than those which received their medical service provision within the U.S.

**Figure 1.** Geographic Location of Elderly Migrants and Medical Service Provision




Source: Own elaboration.

The geographic dispersion and location remoteness of our research participants with Mexican Health Coverage might be explained by considering, according to our data findings, that they have migrated into the U.S. to be closer to their family or to live with their relatives. Based on such criteria proximity to the Mexican boundary line was not a factor for choosing the residential place to live. As subject 3 expressed:

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> "*I go to Juarez once a month for medicine and to see the doctor every three months" and Subject 1 confirmed: "to receive medical attention in Juarez I travel, on average, about 32 to 40 miles for and back…*"

The preference of some of our research subjects to seek for medical attention in Mexico rather than in the U.S. had also relationship with cultural aspects. In our study, almost 30% of the research sub-jects considered the "formalities of the health administration system" as one of the most relevant limita-tions to access to medical services in the U.S. As the U.S. Decision Maker #1 mentioned:

> "*Elder people still have strong attachment to Juarez… they go to Juarez to see specialists and we send them their medical studies*".

This observation is complemented by the Mexican Decision Maker #2:

> "*…when I used to do my medical practice some of my elder patients used to go to my medical office just to talk and they told me once I have already seen you, I feel better*".

In our sample population, the most common medical visits in Mexico were done searching for General Medicine, 25%; Odontology, 12.50%; Cardiology, 4.20%; Ophthalmology, 4.20%; Gynecology, 4.20%; and other, 12.50%.

Finally, some our subjects were also crossing the border to acquire medicines in Mexico rather than in the U.S. because many of those medicines were cheaper or accessible for free to them in Mexican public hospitals. Our data results display the following purchase pattern to acquire medicine in Mexico. 12.6% of our research subjects obtained medicines from the Mexican Institute for Social Security (IMSS) while 8.4% obtained their medicines from private Mexican pharmacies. In the U.S. side, 25% of our research subjects obtained their medicines in Walmart and 16.7% in Walgreens.

## 4. Conclusion

Findings from this research project display several opportunities for future research. We have demonstrated that there is a gap in terms of health provision for elder population migrating from Mexico into the US. The main problem for both the US health institutions and the Mexican health institutions is that they have designed health policies to address health needs for people residing in the national context not in foreign contexts. Notwithstanding, on border contexts, the governmental institutions face the challenge of implementing policies to serve those that has contributed to receive full health coverage, but that have migrated in an adjacent foreign context.

Results clearly have shown that both the US Health Institutions and the Mexican Health Institutions lack administrative strategies and policy design to address the health needs of elderly Mexican migrants into the US. This is a challenge that demand creativity to modify the current provision and administration of health services along the US/Mexico border. In addition, it is an opportunity to incorporate technology

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and to innovate in the administration of health services at the binational level as it happens in the European context (Nedelcu, et al., 2024; Ramnath et al., 2021; Zhigaltsova, 2021).

Finally, we consider that our study could become one of the first evidence for Mexican and US decision makers about the necessity to modify the operation of Health Institutions and Health Programs along the US / Mexico border. The close human and economic interactions that occur daily in such geographic location demonstrate that border regions represent a challenge for static administrative health organizations and health policies.

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**Interviewed decision makers**

Mexican Decision Maker 1: Adriana Martinez Landaverde, Mexican Consulate.

Mexican Decision Maker 2: Lorena Garcia, State Secretary of Health/Program of Elderly People.

Mexican Decision Maker 3: Nubia Denis Rodríguez, Office for Family Development/Program of Elderly People (DIF).

U.S. Decision Maker 1: Ismael Rodríguez, University Medical Center.

U.S. Decision Maker 2: Yvette Lugo, Rio Grande Area Agency on Aging (AAA).

U.S. Academic Expert 1: Shafik Dharamsi, UTEP College of Health Science.

U.S. Academic Expert 2: Guillermina Solis, UTEP College of Health Science.

U.S. Academic Expert 3: Candyce Berger, UTEP College of Health Science.